THE STATE of ALASKA
Department of Commerce, Community, and Economic Development
Division of Corporations, Business and Professional Licensing

Board of Examiners in Optometry
PO Box 110806, Juneau, AK 99811
Phone: (907) 465-2550
Email: *BoardOfOptometry@Alaska.Gov*
Website: *ProfessionalLicense.Alaska.Gov/BoardOfOptometry*

Optometry License Application Instructions

Alaska Statute 08.72.110 states that no person may practice optometry in the state without first obtaining an Alaska license. The State of Alaska provides for licensure of optometrist with therapeutic authority only and no longer offers a restricted license for new applicants.

All Alaska-licensed practitioners with a DEA registration number valid to use in any state or practice location must register with the Alaska Prescription Drug Monitoring Program (PDMP) within 30 days of initial licensure and use the PDMP to review a patient's prescription history each time before prescribing or administering a federally scheduled II or III controlled substance. For more information, please visit *PDMP.Alaska.Gov*

LICENSURE BY EXAMINATION

The following must be received by the division before your application for Optometry License by Examination can be reviewed:

1. APPLICATION
A completed application, signed and notarized (#08-4232, pages 1-7). If a section or question does not apply to you or if you do not have a response, enter N/A in the field or box.

2. FEES
Fees made payable to "State of Alaska."

Nonrefundable Application Fee:	$ 450.00
Initial License Fee:	$ 600.00
State Law Examination Fee:	$ 250.00
Prescription Drug Monitoring Program (PDMP):	$ 0.00
Total Fees Due:	$1,300.00

3. AUTHORIZATION FOR RELEASE OF RECORDS
A completed Authorization for Release of Records form (#08-4232a).

4. TRANSCRIPTS
Official transcripts sent directly to the division from an approved college of optometry indicating OD degree.

5. REFERENCES
Three notarized letters of reference sent directly to the division from the person providing the reference (#08-4232b).

6. VERIFICATION OF LICENSURE
A completed Verification of Licensure form (#08-4232c) sent directly to the division from each jurisdiction where you hold, or have ever held, a license to practice optometry.

7. VERIFICATION OF CURRENT EMPLOYMENT STATUS
Verification of your current employment status and disciplinary history from each federal agency where you are, or have been, employed as an optometrist, if applicable (#08-4232d).

8. DEA REGISTRATION
Copy of a valid DEA registration. Persons with a valid federal DEA registration number must submit proof of two hours of education in pain management and opioid use and addiction completed within two years preceding the date of application.

9. EXAM SCORES
Passing scores on all parts of the written and practical examination administered by the NBEO taken within four years of the date of application and sent directly to the Division from the NBEO (part I, II, III, TMOD, and ISE).

10. CONTINUING EDUCATION

If the date from an approved college of optometry indicating OD degree was greater than 2 years from the date of application, you must submit documentation of 36 hours of continuing education, in accordance with 12 AAC 48.210.

LICENSURE BY CREDENTIALS

The following must be received by the division before your application for Optometry License by Credentials can be reviewed:

1. APPLICATION

A completed application, signed and notarized (#08-4232, pages 1-7). If a section or question does not apply to you or if you do not have a response, enter N/A in the field or box.

2. FEES

Fees made payable to "State of Alaska."

Nonrefundable Application Fee:	$ 450.00
Initial License Fee:	$ 600.00
State Law Examination Fee:	$ 250.00
Prescription Drug Monitoring Program (PDMP):	$ 0.00
Total Fees Due:	$1,300.00

3. AUTHORIZATION FOR RELEASE OF RECORDS

A completed Authorization for Release of Records form (#08-4232a).

4. TRANSCRIPTS

Official transcripts sent directly to the division from an approved college of optometry indicating OD degree.

5. VERIFICATION OF LICENSURE

A completed Verification of Licensure form (#08-4232c) verifying that the applicant has successfully completed all the requirements for, and received, a license to practice optometry from another state or territory of the United States or from a province of Canada that required the applicant to have passed the National Board of Examiners in Optometry (NBEO) examination, sent directly to the Division from the licensing jurisdiction.

6. VERIFICATION OF CURRENT EMPLOYMENT STATUS

Verification of your current employment status and disciplinary history from each federal agency where you are, or have been, employed as an optometrist, if applicable (#08-4232d).

7. CERTIFICATES OF COMPLETION

Certificate of completion of 23 hours in nontopical therapeutic pharmaceutical agent course, or passing TMOD/PAM and a Certificate of completion of 7 hours in optometry and nontopical therapeutic pharmaceutical agent injection education or passing ISE.

8. DEA REGISTRATION

Copy of a valid DEA registration. Persons with a valid federal DEA registration number must submit proof of two hours of education in pain management and opioid use and addiction completed within two years preceding the date of application.

9. EXAM SCORES

Passing scores on an NBEO examination taken at any time sent directly to the division from the NBEO.

10. AFFIDAVIT OF ACTIVE PRACTICE

Affidavit certifying at least 3,120 hours of active licensed clinical practice experience in optometry within 36 months preceding the date of application, signed by a licensed health care professional who is familiar with your practice (#08-4232e).

General Information

APPLICATION PROCESSING:
The average time to process a paper application varies by program but can take several weeks from the date it is received in this office complete with all correct forms, supporting documents and appropriate fees paid. When the application is complete and correct, and all supporting documents have been received and all fees have been paid, the license will be issued. Start the process far enough in advance to allow for processing time. Applications are reviewed in order of receipt in our office, and walk-in customers should not expect immediate review.

LICENSE TERM:
There is no "inactive" status. If you choose not to renew your license, it will lapse. Licenses are issued for a two-year period and expire on December 31 of even-numbered years, regardless of the date of issuance, except licenses issued within 90 days of the expiration date are issued to the next biennial expiration date. One renewal notice will be mailed at least 30 days before license expiration to the last known address of record.

PROFESSIONAL FITNESS QUESTIONS:
A "yes" response in the application does not mean your application will be denied. If you have responded "yes" to any professional fitness questions in the application, be sure to submit a signed and dated explanation, and the charging document and judgement.

DENIAL OF APPLICATION:
Please be aware that the denial of an application of licensure may be reported to any person, professional licensing board, federal, state, or local governmental agency, or other entity making a relevant inquiry or as may be required by law.

RANDOM AUDIT:
If your program requires continuing education, the Division will audit a percentage of the license renewals. If your license is randomly selected for audit, a letter will be sent with instructions to submit documentation as proof you satisfied the continuing competency requirements as stated on this renewal form. Licensees are randomly selected by computer and may be randomly selected as often as the computer program chooses. You must save your documents for at least four years so you can respond to audits.

ADDRESS OR NAME CHANGE:
In accordance with 12 AAC 02.900, it is the applicant's/licensee's responsibility to notify the Division, in writing, of changes of address or name. Name and address change notification forms are available on the Division's website. The address of record with the division will be used to send renewals and all other official notifications and correspondence. The name appearing on the license must be your current legal name.

CERTIFIED TRUE COPIES:
If any of the required documents will be issued under a former name, indicate on the application and submit marriage license and/or court documents that are notarized as a "certified true copy of the original document". To obtain a certified true copy, you must present the notary with the original document along with the photocopy. You must write, "I certify this is a true copy of the original document" and sign your name. The notary will compare the original document with the copy and then notarize your signature.

SOCIAL SECURITY NUMBERS:
AS 08.01.060 and 08.01.100 require that a U.S. Social Security Number be on file with the division before a professional license is issued or renewed for an individual. If you do not have a U.S. Social Security Number, please complete the Request for Exemption from Social Security Number Requirement form (#08-4372) located at *ProfessionalLicense.Alaska.Gov* or contact the division for a copy of the form. This form is required with every application if you do not have a U.S. Social Security Number.

PUBLIC INFORMATION:
Please be aware that all information on the application form will be available to the public, unless required to be kept confidential by state or federal law. Information about current licensees, including mailing addresses, is available on the division's website at *ProfessionalLicense.Alaska.Gov* under License Search.

ABANDONED APPLICATIONS:
Under 12 AAC 02.910, an application is considered abandoned when 12 months have elapsed since correspondence was last received from or on behalf of the applicant. An abandoned application is denied without prejudice. At the time of abandonment, the division will send notification to the last known address of the applicant, who has 30 days to submit a written request for a refund of biennial license and other fees paid. The application fee will not be refunded. If no request for refund is received within that timeframe, no refund will be issued, and all fees will be forfeited.

BUSINESS LICENSES:
The status of a professional license will directly impact the status of an associated business license. Renewal applications for business licenses are mailed separately. For more information about business licenses, (907) 465-2550 or *BusinessLicense.Alaska.Gov*

STALE DOCUMENTS:
Application forms, authorizations and verifications older than 12 months from the date the document was received by the division will be considered stale; the document must be resubmitted as appropriate before the application will be considered by the division or a licensing board. Application documents include the application documents and verifications of licensure from other licensing jurisdictions. (12 AAC 02.915)

PAYMENT OF CHILD SUPPORT:
If the Alaska Child Support Enforcement Division has determined that you are in arrears on child support, you may be issued a nonrenewable temporary license valid for 150 days. Contact Child Support Services at (907) 269-6900 to resolve payment issues.

STATUTES AND REGULATIONS:
The complete set of statutes and regulations for this program are available by written request or online at the division's website: *ProfessionalLicense.Alaska.Gov*

If you would like to receive notice of all proposed regulation changes for your program, please send a request in writing with your name, preferred contact method (mail or email), and the specific program you want to be updated on to the address below.

Regulations Specialist
Department of Commerce, Community, and Economic Development
Division of Corporations, Business and Professional Licensing
EMAIL: *RegulationsAndPublicComment@Alaska.Gov*

Application for Licensure Checklist

Checklist	Document	Provided By
☐	Completed application, signed and notarized (#08-4232, pages 1-7).	You provide
☐	Authorization for Release of Records form (#08-4232a).	You provide
☐	Optometry education transcripts.	You request; school mails directly to our office
☐	Three letters of reference (#08-4232b). *(Examination applicants only.)*	You request; references mail directly to our office
☐	Verification of Licensure from any state, territory, or province, you hold, or have ever held a license (#08-4232c).	You request; jurisdictions mail directly to our office
☐	Verification of licensure/employment with a federal agency.	You request; other agency provides document
☐	NBEO / TMOD / PAM / ISE scores.	You request; agency mails directly to our office
☐	7 hours of injection education certification. *(Credential applicants only.)*	You provide
☐	Copy of DEA registration number (if you have one). Effective July 1, 2018: persons with a valid federal DEA registration number must submit certificate of completion of two hours of education in pain management and opioid misuse and addiction completed within 2 years preceding the date of application.	You provide
☐	Proof of 36 hours of CE if you passed the NBEO two or more years before the date of application. *(Examination applicants only.)*	You request; other agency provides document
☐	3,120 hours of clinical practice verification. *(Credential applicants only.)*	You request; other agency provides document
☐	Charging and closing court documentation for any "yes" answers. If the "yes" answers are health-related, provide a "fit to practice" letter from your health care provider.	You provide or the health care provider submits directly to our office
☐	Written explanation, signed and dated, for any "yes" answers.	You provide
☐	Fees enclosed with application.	You provide

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Optometry License Application

PART I Application Type

☐ Credentials (Licensed in another state)

☐ Examination (NOT licensed in another state or less than 3,120 hours of clinical practice)

NOTE: Apply by examination if you are currently licensed and do not have 3,120 clinical practice hours.

PART II Payment of Fees

Required Fees:	☐ Nonrefundable Application Fee	**$450.00**
	☐ Initial License Fee	**$600.00**
	☐ State Law Examination Fee	**$250.00**
PDMP Fees:	☐ I have an active DEA registration number valid in any state or practice location.	**$ 0.00**
	☐ I do not have an active DEA registration number valid in any state or practice location.	**$ 0.00**

PART III Personal Information

Full Legal Name:			

Provide all other names used (maiden, nicknames, aliases). If any documentation will be received in a prior name, you must provide a certified true copy of the documentation showing proof of legal name change(s).

☐ Not Applicable

☐ Other Names Used: _____

Mailing Address:	P.O. Box or Street	City	State	Zip
Contact Phone:		**Date of Birth:**		

EMAIL AGREEMENT: By choosing to receive correspondence on any matter affecting my license or other business with the Alaska Division of Corporations, Business and Professional Licensing, I agree to maintain an accurate email address through the MY LICENSE web page. I understand that failure to check my email account or to keep the email address in good standing may result in an inability to receive crucial information, potentially resulting in my inability to obtain or maintain licensure.

Email Address:		**Select One:**	☐ Send my Correspondence Electronically ☐ Send my Correspondence by Mail

Note: If both boxes are selected above, you will receive correspondence electronically.

SOCIAL SECURITY NUMBER: AS 08.01.060 requires you to provide your United States Social Security Number. It is considered confidential information and will not be publicly disclosed; it may be used to verify inter-state licensure.	

PART IV General Education Information

Name of College or University:		**Location:** (City, State)	
Date Attended From:		**Date Attended To:**	
Degree Awarded:		**Date Awarded:**	

PART V Optometry Education Information

School of Optometry Name:		**Location:** (City, State)	
Date Attended From:		**Date Attended To:**	
Degree Awarded:		**Date Awarded:**	

PART VI Examinations

List all exams and courses taken. For online courses, list the company name and website.

OE Tracker Number:	

Course	Location	Date Completed	Result
NBEO Exam – Part I			☐ Pass ☐ Fail
NBEO Exam – Part II			☐ Pass ☐ Fail
NBEO Exam – Part III			☐ Pass ☐ Fail
23 Hours Nontopical Therapeutic Agent / TMOD / PAM			☐ Pass ☐ Fail
Injection Skills Education (ISE)			☐ Pass ☐ Fail

PART VII Federal Agency Employment

Have you ever been employed as an optometrist with a federal agency? Attach a separate sheet if necessary.	☐ No ☐ Yes		
Branch:			
Start Date:		**End Date:**	
Reason for Leaving:			
Location(s) Where You Practiced:			

PART VIII DEA Registration and PDMP Acknowledgment

1. **Providers with a DEA registration number valid to use in any state or practice location must register with the PDMP. Do you have a DEA Registration number?**

☐ **a.** **NO**, I do not have an active DEA registration number valid to use in any state or practice location. I understand if I obtain a DEA registration number, I must register with the Alaska PDMP within 30 days as required by the board. I will refer to all applicable authorizing statutes, regulations cited above, and comply with mandatory use. (Skip to Part IX)

☐ **b.** **YES**, I have an active DEA registration number valid to use in any state or practice location. I understand I must register with the Alaska PDMP within 30 days of receiving this permit or license, as required by the board, and will comply with mandatory use as required by AS 17.30.200 and 12 AAC 40.967.

☐ I acknowledge I must review a patient's prescription history prior to prescribing or administering a federally scheduled II or III controlled substance.

If I have a change in DEA registration number or status, I also understand I must promptly submit the DEA Registration Status Change Form (#08-4763).

If you're unsure of the DEA issue date, indicate January 1st of the estimated year.

DEA Registration Number:		**Issue Date:**		**Expiration Date:**	

PART IX Opioid Education

☐ I have earned at least two hours of education in pain management, opioid use, and addiction; I will provide a Certificate of Completion that confirms at least two hours of credit covering all three areas of the required subject matter: pain management, opioid use, and addiction.

☐ I request a waiver of the requirement for two hours of education in pain management, opioid use, and addiction until I apply for a DEA registration number.

Opioid Course Name:		**Date Course Completed:**	
Opioid Course Location:			

PART X Professional License(s)

Please list all states, territories, provinces, or foreign countries in which you currently hold or have ever held a license to practice optometry. Ensure verifications are sent to the division directly from the governing body.

State or Jurisdiction	License Number	Issue Date	Expiration Date	Endorsements
				☐ TPA ☐ Orals ☐ Glaucoma ☐ DPA ☐ Injections ☐ Other: __________
				☐ TPA ☐ Orals ☐ Glaucoma ☐ DPA ☐ Injections ☐ Other: __________
				☐ TPA ☐ Orals ☐ Glaucoma ☐ DPA ☐ Injections ☐ Other: __________
				☐ TPA ☐ Orals ☐ Glaucoma ☐ DPA ☐ Injections ☐ Other: __________
				☐ TPA ☐ Orals ☐ Glaucoma ☐ DPA ☐ Injections ☐ Other: __________
				☐ TPA ☐ Orals ☐ Glaucoma ☐ DPA ☐ Injections ☐ Other: __________

PART XI Professional Associations

List all optometry memberships.

Name	Location

PART XII Professional References (Exam Applicants Only)

Please list three references. The included form #08-4232b must be completed by the three references who have knowledge of your character and professional abilities. This form must be mailed from the reference directly to the division.

Reference Name	Reference Address	Reference Phone Number
1.		
2.		
3.		

PART XIII Practice History

Beginning with your current position, provide a chronological listing of all practice-related activities for the last 5 years. Do not attach a resume; we require the use of this form. If you are a traveler, do not put "various locations." You must report every facility location/city and state where you have practiced. Make copies as necessary.

Clinic Name:		**Position Held:**	
Clinic Address:	Street City State Zip		
Employment Start Date:		**Employment End Date:**	
Type of Practice:	☐ Self ☐ Group ☐ Private ☐ Commercial ☐ HMO ☐ Military ☐ Federal ☐ Other: _____		

Clinic Name:		**Position Held:**	
Clinic Address:	Street City State Zip		
Employment Start Date:		**Employment End Date:**	
Type of Practice:	☐ Self ☐ Group ☐ Private ☐ Commercial ☐ HMO ☐ Military ☐ Federal ☐ Other: _____		

PART XIII Practice History (continued)

Beginning with your current position, provide a chronological listing of all practice-related activities for the last 5 years. Do not attach a resume; we require the use of this form. If you are a traveler, do not put "various locations." You must report every facility location/city and state where you have practiced. Make copies as necessary.

Clinic Name:		**Position Held:**	
Clinic Address:	Street City State Zip		
Employment Start Date:		**Employment End Date:**	
Type of Practice:	☐ Self ☐ Group ☐ Private ☐ Commercial ☐ HMO ☐ Military ☐ Federal ☐ Other: ___________________		

Clinic Name:		**Position Held:**	
Clinic Address:	Street City State Zip		
Employment Start Date:		**Employment End Date:**	
Type of Practice:	☐ Self ☐ Group ☐ Private ☐ Commercial ☐ HMO ☐ Military ☐ Federal ☐ Other: ___________________		

Clinic Name:		**Position Held:**	
Clinic Address:	Street City State Zip		
Employment Start Date:		**Employment End Date:**	
Type of Practice:	☐ Self ☐ Group ☐ Private ☐ Commercial ☐ HMO ☐ Military ☐ Federal ☐ Other: ___________________		

Clinic Name:		**Position Held:**	
Clinic Address:	Street City State Zip		
Employment Start Date:		**Employment End Date:**	
Type of Practice:	☐ Self ☐ Group ☐ Private ☐ Commercial ☐ HMO ☐ Military ☐ Federal ☐ Other: ___________________		

Clinic Name:		**Position Held:**	
Clinic Address:	Street City State Zip		
Employment Start Date:		**Employment End Date:**	
Type of Practice:	☐ Self ☐ Group ☐ Private ☐ Commercial ☐ HMO ☐ Military ☐ Federal ☐ Other: ___________________		

PART XIV Professional Fitness Questions

The following questions must be answered. "Yes" answers may not automatically result in license denial.

For each "yes" response to any question, you must provide an explanation and documentation. Use the letter of explanation form (#08-4752) appended to this application; include full details, dates, locations, type of action, organizations or parties involved, and specific circumstances. A separate letter of explanation form must be provided for each "yes" answer documented below. Documentation includes copies of court orders, charging documents, board, or license actions, etc.

The contents of licensing files are generally considered public records. If you believe that the additional information you are attaching to explain a "yes" answer should be considered confidential, state that in the attachment. A request for confidentiality may or may not be granted.

When in doubt, disclose and explain.

1.	Have you been convicted of a crime or are you currently charged with committing a crime, or is any such action pending? For purposes of this question, "crime" includes a misdemeanor, felony, or a military offense, including (but not limited to) a conviction involving driving under the influence (DUI) or driving while intoxicated (DWI), driving without a license, reckless driving, or driving with a suspended or revoked license. "Convicted" includes having been found guilty by verdict of a judge or jury, having entered a plea of guilty, nolo contendere or no contest, or having been given probation, a suspended imposition of sentence, or a fine.	☐ **Yes** ☐ **No**
2.	Have you had a professional license denied, revoked, suspended, or otherwise restricted, conditioned, or limited or have you surrendered a professional license, been fined, placed on probation, reprimanded, disciplined, or entered into a settlement with a licensing authority in connection with a professional license you have held in any jurisdiction including Alaska and including that of any military authorities or is any such action pending?	☐ **Yes** ☐ **No**
3.	Are you now or have you been in the last five years diagnosed with or treated for bipolar disorder, schizophrenia, paranoia, psychotic disorder, substance abuse, depression (except for situational or reactive depression) or any other mental or emotional illness which may impair or interfere with your ability to practice optometry?	☐ **Yes** ☐ **No**
4.	Are you now or have you been in the last five years been treated for, or addicted to, or excessively used, or misused, alcohol, narcotics, barbiturates or habit-forming drugs?	☐ **Yes** ☐ **No**
5.	Do you have a physical disability or illness, which could affect your ability to practice as an optometrist?	☐ **Yes** ☐ **No**

"Yes" Answers

If you answered "yes" to questions 3, 4, or 5, in addition to your personal statement, you must submit a statement from your health care provider indicating your ability to safely practice optometry. Applications submitted without the appropriate attachments will be considered incomplete and will not be processed.

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Notary Signature Page

PART XV Notarized Signature

I hereby certify that I am the person herein named and subscribing to this application and that I have read the complete application, and I know the full content thereof. I declare that all of the information contained herein, and evidence or other documents submitted herewith are true and correct.

I understand that any falsification or misrepresentation of any item or response in this application, or any attachment hereto, or falsification or misrepresentation of documents to support this application, is sufficient grounds for denying, revoking, or otherwise disciplining a license or permit to practice in the state of Alaska.

I further understand that if information is provided in the Criminal History Report from the State of Alaska or FBI that I did not report, my license may be subject to disciplinary action.

I further understand that it is a Class A misdemeanor under Alaska Statute 11.56.210 to falsify an application and commit the crime of unsworn falsification.

A person who makes a false statement on this application may be subject to civil and criminal penalties, including prosecution for perjury (AS 11.56.200 & AS 11.56.230).

Notary Stamp					
	Applicant Printed Name:				
	Applicant Signature:				
	Notary Public for State of:		**Subscribed and Sworn to Before me on this Day:**		
	Notary Signature:		**My Commission Expires:**		

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Authorization for Release of Records

I hereby authorize the Alaska Division of Corporations, Business, and Professional Licensing and its investigators to examine my medical and dental records, employment and education records including all training which pertains to my medical practice, and any records pertaining to litigation, judgments, suits, and/or settlements, and any law enforcement records pertaining to me and discuss them with persons having possession of them. I also expressly permit and authorize the release of any and all such records pertaining to me to the Alaska Division of Corporations, Business, and Professional Licensing and its investigators. This release also applies to all records that pertain to credentialing records at facilities at which I have applied for or held privileges to practice medicine.

I authorize the division to discuss my records with persons or organizations that are considered appropriate by the division in connection with an official investigation, and to provide copies of my records to those persons or organizations deemed appropriate by the division.

This release also applies to any documents or records which contain information pertaining to psychiatric, psychological, drug, or alcohol evaluation, counseling, diagnosis or treatment received by me and which were prepared or made in conjunction with, or under the authority or guidance of any local, state, or federal law which relates to psychiatric, drug or alcohol evaluation, diagnosis or treatment, including all information previously identified, collected, or stored under the authority of any state or federal law, including 42 CFR Part 2.

I request that upon presentation of this release, or a Certified True Copy thereof, that you provide copies of those records to the division and/or its investigators, and/or representatives of the Office of the Attorney General of the State of Alaska.

This authorization expires one (1) year from the date of my signature below.

Name:	First Middle Last		
Full Address:	P.O. Box or Street City State Zip		
Phone:		**Date of Birth:**	
Email:			
Signature:		**Date Signed:**	

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Affidavit of Professional Reference

License by examination applicants must provide references from THREE (3) individuals not related to the applicant by blood or marriage attesting to the applicant's good moral character and capacity to competently and safely practice optometry.

The reference must be one of the following:

a) an optometrist currently licensed in this state or another state or territory of the United States or in Canada;
b) an instructor or official from the applicant's school of optometry;
c) a supervisor of the applicant through applicant's employment in optometry or in a related field.

→ Applicant:

Please complete the identifying information below and forward a copy of this form to the appropriate individuals. *Make additional copies of this form, as needed.*

Full Legal Name:			
Mailing Address:	P.O. Box or Street City State Zip		
Applicant Signature:		**Date Signed:**	

→ Reference:

Please provide the information requested below for the applicant identified in this form and send document directly to the Alaska State Board of Examiners in Optometry at the letterhead address.

Reference Name:			
Reference Address:	P.O. Box or Street City State Zip		
Reference Phone:		**Reference Email:**	
Associated with Applicant from Date:		**Associated with Applicant to Date:**	

My professional relationship to the applicant is:

- ☐ An optometrist currently licensed in the United States or Canada.
- ☐ An instructor or official from the applicant's school of optometry.
- ☐ A supervisor of the applicant through applicant's employment in optometry or related field.

1. Please comment on the applicant's qualifications, ability, character, etc.:

Notary Stamp	**Reference Printed Name:**			
	Reference Signature:			
	Notary Public for State of:		**Subscribed and Sworn to Before me on this Day:**	
	Notary Signature:		**My Commission Expires:**	

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Verification of Licensure

→ **Applicant:** Please complete the identifying information below and forward a copy of this form to all states, territories, or jurisdictions where you currently are or have ever been licensed. *Make additional copies of this form, as needed.*

Applicant Name:		**Date of Birth:**	
Mailing Address:	P.O. Box or Street / City / State / Zip		
Email:		**License Number:**	
Applicant Signature:		**Date Signed:**	

→ **Licensing Agency or State Board:** Please complete this bottom part for the applicant identified above and return the form directly to the Alaska State Board of Examiners in Optometry at the letterhead address.

Licensee Name: (As Shown in Your Records)		**State or Jurisdiction:**	
License Number:		**License Status:**	
Original Issue Date:		**Expiration Date:**	

1. Is the licensee authorized to prescribe all glaucoma pharmaceutical agents for therapeutic purposes (TPA)? ☐ Yes ☐ No

2. Has the license ever been revoked, suspended (voluntary or involuntary), placed on probation, or restricted in any way? ☐ Yes ☐ No

3. Is the licensee the subject of a pending disciplinary proceeding? ☐ Yes ☐ No

4. Has the licensee ever been the subject of an unresolved complaint, review procedure, or disciplinary action? ☐ Yes ☐ No

"Yes" Answers

If you answered "yes" to any question above, please attach a detailed explanation or documentation signed and dated by the person whose signature appears below.

Board Seal	**Signature:**		**Date Signed:**	
	Printed Name:		**Title:**	
	Email:		**Phone:**	

THE STATE of ALASKA
Department of Commerce, Community, and Economic Development
Division of Corporations, Business and Professional Licensing

Board of Examiners in Optometry
PO Box 110806, Juneau, AK 99811
Phone: (907) 465-2550
Email: *BoardOfOptometry@Alaska.Gov*
Website: *ProfessionalLicense.Alaska.Gov/BoardOfOptometry*

Verification of Federal Employment

→ Applicant: Please complete the identifying information below and forward a copy of this form to all federal agencies where you currently are or have ever been licensed. *Make additional copies of this form, as needed.*

Applicant Name:		**Date of Birth:**	
Mailing Address:	P.O. Box or Street / City / State / Zip		
Applicant Signature:		**Date Signed:**	

→ Federal Employer: Please complete this bottom part for the applicant identified above and return the form directly to the Alaska State Board of Examiners in Optometry at the letterhead address.

Licensee Name: (As Shown in Your Records)		**Jurisdiction:**	
License Number:		**License Type:**	
Employment Start Date:		**Employment End Date:**	
Reason for Leaving:			

1. Has the applicant ever been subject of an adverse decision based upon a complaint, review procedure, or other disciplinary proceeding, or of an unresolved complaint, investigation, review procedure, or other disciplinary proceeding undertaken by your facility? ☐ Yes ☐ No

2. Is any such action pending? ☐ Yes ☐ No

If yes, for what reason: _____

3. Has the applicant ever been the subject of an unresolved or an adverse decision based upon a complaint, investigation, review procedure, or other disciplinary proceeding undertaken by your facility that relates to criminal or fraudulent activity, optometric or on the safety or well-being of patients? ☐ Yes ☐ No

4. To your knowledge, is there any derogatory information regarding this applicant? ☐ Yes ☐ No

"Yes" Answers

If you answered "yes" to any question above, please attach a detailed explanation or documentation signed and dated by the person whose signature appears below.

Notary Stamp	**Reference Printed Name:**			
	Reference Signature:			
	Notary Public for State of:		**Subscribed and Sworn to Before me on this Day:**	
	Notary Signature:		**My Commission Expires:**	

THE STATE of ALASKA
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Affidavit of Clinical Optometry Experience

→ Applicant: Please complete this top part and then forward it to each licensed health care professional who is familiar with your practice for a total of 3,120 hours within the last 36 months. It must be returned directly to the Division to the letterhead address. *Make additional copies of this form, as needed.*

Full Legal Name:			
Email Address:		**Phone Number:**	
Applicant Signature:		**Date Signed:**	

→ Reference: The information below must be completed and sent directly to the Division by a licensed health care professional who is familiar with the applicant's practice; it may not be completed or returned by the applicant.

Name of Professional Clinic or Institution:			**Number of Hours Practiced:**	
Dates of Employment: (Within the last 36 mo.)	**Begin Date:**		**End Date:**	
Reference Name:			**Title:**	
Address of Professional Clinic or Institution:	Street	City	State	Zip
Phone Number:				
Professional License Number:			**State:**	
Notary Stamp	**Reference Printed Name:**			
	Reference Signature:			
	Notary Public for State of:		**Subscribed and Sworn to Before me on this Day:**	
	Notary Signature:		**My Commission Expires:**	

THE STATE of ALASKA

Department of Commerce, Community, and Economic Development
Division of Corporations, Business and Professional Licensing

FOR DIVISION USE ONLY

State of Alaska
Department of Commerce, Community, and Economic Development
Division of Corporations, Business and Professional Licensing
PO Box 110806, Juneau, AK 99811
Phone: (907) 465-2550

Credit Card Payment Form

All major credit cards are accepted. For security purposes, do not email credit card information. Include this credit card payment form with your application.

Name of Applicant or Licensee: _____

Profession Type (e.g., Acupuncture):

License Number *(if applicable)*: _____

I wish to make payment by credit card for the following *(check all that apply)*: **AMOUNT**

- ☐ Application Fee: _____ _____
- ☐ License or Renewal Fee: _____ _____
- ☐ Other *(fine, exam, etc.)*: _____ _____

1. _____ _____
2. _____ _____

TOTAL: _____

Name *(as shown on credit card)*: _____

Mailing Address: _____

Phone Number: _____ Email *(optional)*: _____

Signature of Credit Card Holder: X _____

08-4438 Rev 12/06/2022 Credit Card Payment Form (all major cards accepted)

CREDIT CARD INFO: Your payment cannot be processed unless all fields are completed!

1. Credit Card Number: -
2. Expiration Date: -
3. Security Code: -

All 3 fields **MUST** be completed!

This section will be destroyed after the payment is processed.

THE STATE of ALASKA
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Professional Licensing
PO Box 110806, Juneau AK 99811
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Website*: ProfessionalLicense.Alaska.Gov*

Letter of Explanation for a Professional Fitness "Yes" Answer

Use this form only to explain and document any professional fitness "Yes" answers. A "Yes" answer is not necessarily disqualifying but concealing one may be.

Each "Yes" answer requires a separate explanation and associated documentation. Submit all relevant documentation with this form, even if you have previously provided it.

- **Explanations** include full details, dates, locations, type of action, organizations or parties involved, and specific circumstances. If the space provided is insufficient, make additional copies as needed.
- **Documentation** includes copies of court orders, charging documents, board or license actions, decisions against your professional certification, satisfaction of consent agreements (fines paid, community service completed, off probation, etc.), and fitness to practice letters (statement from your provider that you are safe to practice if you check "Yes" to any of the questions regarding mental or physical health, or drug or alcohol abuse or addiction).
- **Disciplinary actions** may include but not be limited to: suspension, surrender, revocation, probation, academic probation, reprimand, censure, restricted license, limited license, conditioned license, or letters of counseling, concern, advice, warning, caution, admonishment, or reprimand.

If you have multiple "Yes" answers or multiple incidents for any professional fitness question, you must use a separate copy of this form and provide a full explanation and documentation for each incident.

The contents of licensing files are public records. If you believe that the additional information you are attaching to explain a "Yes" answer should be considered confidential, state that in the attachment. A request for confidentiality may or may not be granted according to state law.

☐ ⇦ **Write the professional fitness question number you are answering "Yes" to in the box.**

Location of Incident:		**Date of Incident:**	
Explanation of Incident:			
When in doubt, disclose and explain. **Make copies as necessary.**			

Did you attach all applicable documents associated with this incident?

☐ Court orders ☐ Consent agreements ☐ Disciplinary actions ☐ Charging documents
☐ Court records ☐ Fitness to practice ☐ All other documentation related to this incident
☐ I have additional incidents for this "Yes" answer, or "Yes" answers to other Professional Fitness questions and have attached a separate copy of this form for each incident.

Full Name:		**PL Code:**	
Signature:		**Date:**	

You must submit one form for each "Yes" answer. Make copies of this form as necessary.